STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E116	A. BUILDING _____ B. WING _____	C 07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of personnel files, inservice training records, a facility investigation report and policies and procedures, and interview, the facility failed to implement policies and procedures to protect one resident (#2) from potentially aggressive behavior by one resident (#1) of five residents reviewed and failed to provide abuse training for two Certified Nursing Assistants (CNA #1, #2) of two personnel files reviewed. The findings included: Resident #1 was admitted to the facility on February 11, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Hypertension, Anxiety and Dementia. Medical record review of the Minimum Data Set dated February 24, 2010, revealed the resident had short-term memory problems and difficulty in decision-making in new situations only and was independent in transfers and ambulation. Resident #2 was admitted to the facility on March 17, 2009, with diagnoses including Pancreatic Cancer, Senile Dementia and Renal Failure. Medical record review of the Minimum Data Set dated July 1, 2010, revealed the resident had	F 226	The submission of the Plan of Correction does not constitute agreement on the part of Bristol Nursing Home that the deficiencies cited within the report represent deficient practices on the part of Bristol Nursing Home. **F226 POLICIES & PROCEDURES CONCERNING NEGLECT & ABUSE** **Corrective Action** 7/26/10-Current facility staff were in serviced and received a copy of the abuse/neglect policy from the SDC. **Identification** Current residents have the potential to be affected. **Systematic Changes** DON/ADON will in-service facility staff on the abuse/neglect policy at time of orientation. DON/ADON will in-service facility staff on the abuse/neglect policy quarterly and anytime an occurrence/allegation arises. **QA/Monitoring** DON/ADON will review abuse/neglect in-services logs and signed acknowledgements at time of hire quarterly with QA Committee.	7/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Robinson Moneyhe — TITLE: Administrator — (X6) DATE: 8-3-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 short and long-term memory problems and moderately impaired decision-making skills and was totally dependent on staff for all activities of daily living. Review of a facility abuse investigation report dated April 8, 2010, documented by CNA #1 revealed, "At 3:00 am (a.m.) the call light to (resident #1's) room went off...went to answer call light where I saw (resident #1) standing over (resident #2) with a blue water pitcher...told (resident #1) to put the water pitcher down and to leave (resident #2) alone. (Resident #1) put the pitcher down and layed (laid) down...about 5 to 6 minutes later the call light went off again. (CNA #2) went to answer the call light...could hear (resident #1) yelling at (resident #2) telling...to shut up. At about 3:15 we was in the hall and we could hear (resident #1) yelling. We (CNA #1 and #2) went into the room where we removed (resident #1)...(resident #1) walking all over the room screaming that (resident #2) was talking to (too) loud...stayed in the hall till (until) about 4:15 a.m....heard noise coming from the room...went down there...health (resident #1) hitting stuff on the table...saw (resident #1 standing over (resident #2) with a Ensure can...told (resident #1) to put it down...slammed it on the table...kept saying...was not going to hit (resident #2) with the can...put (resident #1) back in...wheelchair where...stayed in the hallway until about 6:00 a.m...." Medical record review of a nurse's note by the Registered Nurse (RN #1) Supervisor (undated) revealed, "...reported to me...(resident #1) had been hitting on...roommate (resident #2)...went to room...seen redish (red) areas to the left forearm (of resident #2).	F 226	(Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Social Services Director, Business Office Manager, Activities Director, Dietary Manager, Environmental Manager, and Maintenance Director.) QA Committee will make recommendations to improve the understanding and implementation the abuse/neglect policy and determine when compliance has been met.	

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F 226	Continued From page 2 Interview on July 20, 2010, at 10:30 a.m., in the classroom, with the RN Supervisor (#1) confirmed RN #1 assessed resident #2 at 7:00 a.m., on April 8, 2010, and observed reddened areas to the left forearm. Review of the facility's abuse policies and procedures in place on April 8, 2010, revealed, "...If the abuser is another resident, remove him/her from the scene..." Review of the personnel file for CNA #1 revealed CNA #1 was employed by the facility on February 22, 2010. Continued review of the personnel file and of the facility's inservice training records for orientation of CNA #1 revealed CNA #1 had not been trained on abuse during orientation. Review of the personnel file and abuse training records for CNA #1 and interview, in the classroom on July 20, 2010, at 12:00 p.m., with the Assistant Director of Nursing/Staff Education confirmed CNA #1 had not been trained on the facility's abuse policies and procedures since being employed by the facility on February 22, 2010. Review of abuse training records on July 20, 2010, at 12:20 p.m., in the classroom, with the Administrator, confirmed CNA #1 had not been trained on the facility's abuse policies and procedures since being employed by the facility. Review of the personnel file for CNA #2 revealed CNA #2 was employed by the facility on July 20, 2009. Continued review of the personnel file and of the facility's inservice training records for orientation of CNA #2 revealed CNA #2 had not	F 226		

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F 226	Continued From page 3 been trained on abuse during orientation. Review of the personnel file and abuse training records for CNA #2 and interview, in the classroom on July 20, 2010, at 12:00 p.m., with the Assistant Director of Nursing/Staff Education confirmed CNA #2 had not been trained on the facility's abuse policies and procedures since being employed by the facility on July 20, 2009. Review of abuse training records on July 20, 2010, at 12:20 p.m., in the classroom, with the Administrator, confirmed no documentation CNA #2 had been trained on the facility's abuse policies and procedures since being employed by the facility on July 20, 2009. Interview on July 20, 2010, at 12:45 p.m., in the classroom, with the Administrator confirmed resident #1 displayed aggressive behavior towards resident #2 at 3:00 a.m., on April 8, 2010, and confirmed the residents were not separated until 3:30 a.m. Telephone interview on July 20, 2010, at 2:45 p.m., with CNA #1 revealed CNA #1 "never saw (resident #1) hit or lay a hand on (resident #2)" and resident #1 "did not tell me (resident #1) hit (resident #2)." Continued interview with CNA #1 confirmed CNA #1 observed resident #1 standing over resident #2 at 3:00 a.m., on April 8, 2010, with a "sippy cup" in the hand. Continued interview with CNA #1 confirmed resident #1 was not removed from the room until 3:30 a.m., and was returned to the room at 4:15 a.m. Continued interview with CNA #1 confirmed resident #1 was observed again, after 4:15 a.m., standing over resident #2 holding an Ensure can, and resident #1 was removed from the room again until "about	F 226		

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F 226	Continued From page 4 6:00 a.m." Continued interview with CNA #1 confirmed CNA #1 had not been trained on abuse since employed by the facility. C/O #25577	F 226		